

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155121		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2012	
NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT LAFAYETTE				STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION ST LAFAYETTE, IN 47904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/05/12</p> <p>Facility Number: 000051 Provider Number: 155121 AIM Number: 100275490</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Rosewalk Village at Lafayette was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This facility was consisted of the original two story building with a one story section on the front and</p>		K0000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155121		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2012	
NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT LAFAYETTE				STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION ST LAFAYETTE, IN 47904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>a one story Physical Therapy wing added to the first floor D wing and was fully sprinklered. The construction was determined to be of Type III (211) and completed prior to March 1, 2003. The facility has a fire alarm system with system wide smoke detection in the corridors and spaces open to the corridors. Battery powered smoke detectors protect each resident room. The facility has the capacity for 155 residents and had a census of 123 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/08/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155121		X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2012	
NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT LAFAYETTE				STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION ST LAFAYETTE, IN 47904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
K0046 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 2 battery powered emergency lighting fixtures on the Auguste's Unit would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice affects visitors, staff and 28 residents on the Auguste's Unit.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/05/12 at 3:50 p.m., the battery powered emergency light fixture near room 111 failed to illuminate when tested twice. The maintenance director said at the time of observation, he did not know the light was not working.</p> <p>3.1-19 (b)</p> <p>2. Based on observation and interview, the facility failed to ensure emergency powered exit</p>		K0046	<p>Please consider this plan of correction as our credible allegation of compliance to the Life Safety survey conducted on June 5th of 2012. Please respectfully consider desktop review for this submitted plan of correction.</p> <p>K046 We have installed a new light bulb in the battery powered emergency light located in the Memory Care unit and have added emergency egress lighting in the laundry room.</p> <p>All resident located within the Memory care unit and employees who work in the laundry department had the potential to be negatively impacted by this deficient practice.</p> <p>We will utilize the PM check system to make sure this deficient practice does not occur again. Also, the Maintenance Director and his assistant will make daily rounds through the facility.</p> <p>We will implement the CQI tool entitled, "Life Safety Review" for four weeks, followed by monthly for three months, and then</p>		06/21/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155121		X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2012	
NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT LAFAYETTE				STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION ST LAFAYETTE, IN 47904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>egress lighting was provided in 1 of 1 exit corridors for the laundry smoke compartment. LSC 7.9.1.1 requires emergency lighting be provided for means of egress, ways leading to a public way. This deficient practice could affect visitors and 4 staff.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/05/12 at 4:10 p.m., the exit corridor for the laundry and adjacent rooms in the same smoke compartment was not provided with emergency lighting. The maintenance director acknowledged at the time of observation, the area was left in total darkness when the power went out.</p> <p>3.1-19(b)</p>			<p>quarterly thereafter. The Maintenance Director will be responsible for the implementation and a threshold of 95% must be met or a action plan implemented.</p> <p>Completion date: 6/21/2012.</p>			